TRANSMITTAL FOR MEDICAID LEVEL OF CARE ELIGIBILITY

State Form 46018 (R2 / 7-99) / HCBS 0007

☐ Aged or Disabled ☐ Autism ☐ ICF / MR ☐ Medically Fragile Children ☐ TBI

Name	Medicaid number
Address	
City, state, ZIP code	
Name of guardian	
Address	
City, state, ZIP code	
Name of Case Manager requesting L.O.C.	☐ BDDS ☐ AAA ☐ Waiver Only
Name of agency	
Address	
City, state, ZIP code	Telephone number ( )

Purpose of Level of Care Determination

☐ Initial ☐ Annual Redetermination ☐ Other *(specify)* _____

Waiver Displacement Status

☐ Diversion ☐ Deinstitutionalization From:
☐ Nursing Facility ☐ ICF / MR

Name of facility

Address of facility *(number and street, city, state and ZIP code)*

Date *(month, day, year)*

The diagnostic information is a current and valid reflection of the individual.

Signature of reviewer

NURSING FACILITY RESIDENTS ONLY

OBRA 1987 Residential Alternative Offered:

☐ Not Applicable

☐ Residential Choice *(attach form)*

STATE OFFICE OF MEDICAID POLICY AND PLANNING USE ONLY

This application cannot be finalized due to:

☐ Missing Forms ☐ Missing Data ☐ Clarification needed

Comments

☐ **Approved for Level of Care**
☐ Hospital ☐ ICF / MR ☐ NF / I ☐ NF / S ☐ NF / TBI

☐ **Disapproved for Level of Care - SEE ATTACHMENT**
☐ Hospital ☐ ICF / MR ☐ NF / I ☐ NF / S ☐ NF / TBI

Signature and title	Date *(month, day, year)*